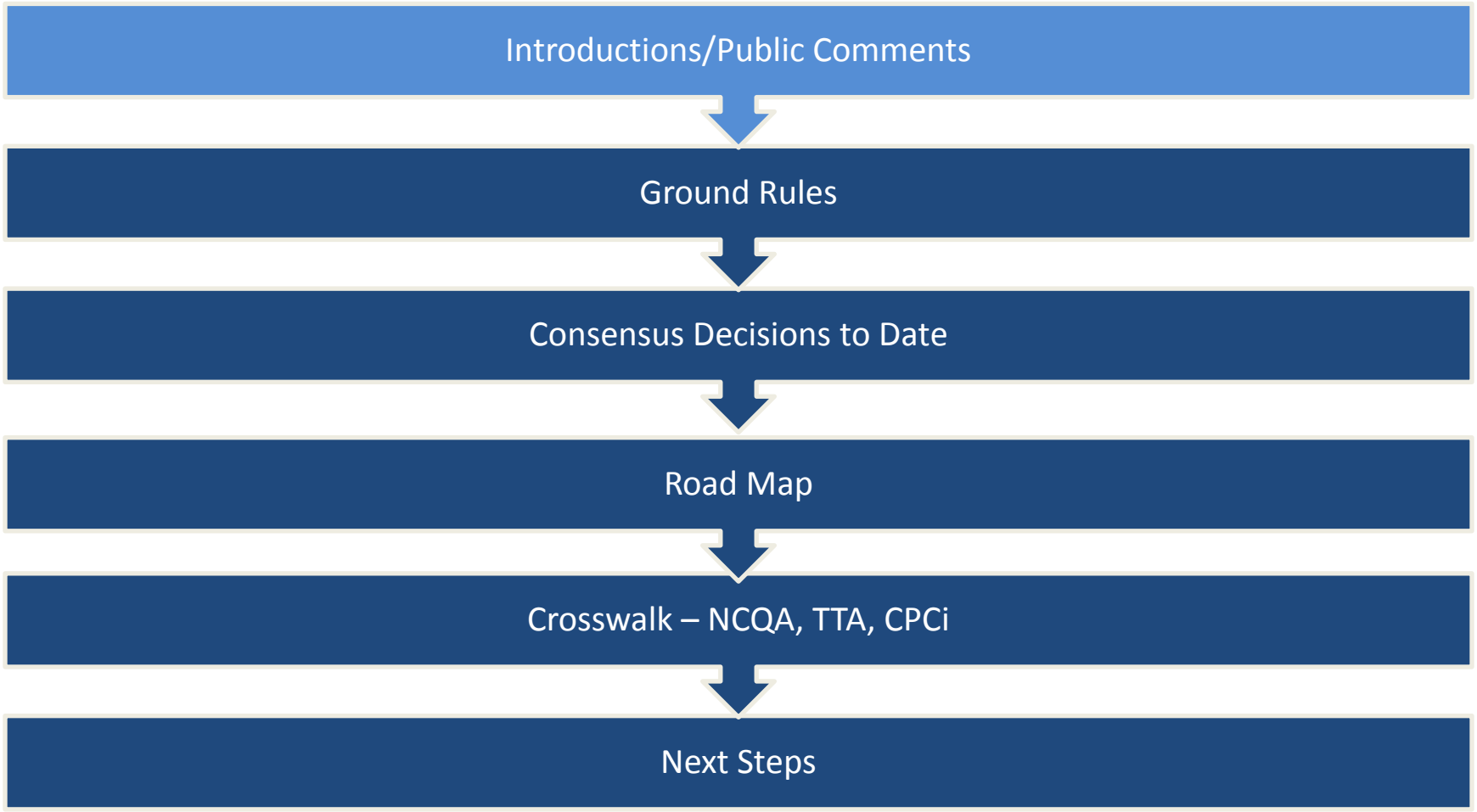
# Practice Transformation Taskforce Meeting

November 4th, 2014

# Agenda


Introductions/Public Comments
Ground Rules
Consensus Decisions to Date
Road Map
Crosswalk – NCQA, TTA, CPCi
Next Steps

# Task Force Ground Rules

- Expectations of taskforce members:
  - Presence
    - Attend meetings
    - Prepare and participate between meetings as needed to move issues along
  - Outlook
    - Leave jobs and titles at the door; focus on best interest of CT citizens
    - Look for consensus to make recommendations to PMO

# Task Force Ground Rules

- Expectations of taskforce members:
  - Action
    - Find solutions for proposed questions
    - Build ideas and be proponent of change and transformation
    - Be vocal and share the importance of our mission
  - Standing Up and Stepping Back
    - Be respectful to all in the room; please give everyone the chance to voice their opinions; try to limit comments to <2min
    - Focus on the task at hand and the topic being discussed at the moment
    - After the meeting, you are invited to raise process and content issues with the Executive Team

# Consensus Decisions

- Use of NCQA PCMH 2014 standards as foundation for Advanced Medical Home (AMH) Glide Path Program
- Require NCQA PCMH recognition as a condition for completion of the AMH Glide Path Program

# Consensus Decisions

- **Plus** selected modifications:
  - Tailor certain must pass elements and critical factors to emphasize key elements of our vision related to
    - Patient centered care
    - Health equity
    - Integrated behavioral health
  - Keep in mind practice burden, avoid the “impossible lift”
  - Use transformation vendors to achieve our vision by emphasizing certain capabilities, going “beyond the standards” in the transformation process

# Ad Hoc Groups

- Integrated Behavioral Health (BH) Design Group
  - *Joint* PTTF and Quality Council design group, co-led by work group members
  - Additional outside stakeholder participants
  - Recommendations:
    - To PTTF for the 11/18 meeting regarding BH and AMH standards
    - To Quality Council regarding quality measures that align with AMH capabilities
    - To PTTF regarding integrated BH model for the Community and Clinical Integration Program

# Community and Clinical Integration Program (CCIP)

- Targeted Technical Assistance Areas
- Learning Collaboratives
- Design Groups
  - Integrated behavioral health
- Full program design will occur Quarter 1

# Goals for 11/4 and 11/18

- Complete standards recommendation:
  - Identify additional must-pass elements and critical factors
  - Identify areas of special emphasis for transformation vendors
  - Create new standards/elements/factors (if needed)

# Intro to Crosswalk

- Our AMH Standards are based on NCQA standards, elements, and factors
- NCQA standards contain “must pass” elements and “critical factors” that every practice has to meet.
- Crosswalk lists all of the 2014 standards and the NCQA “must pass” elements and “critical factors”

# Intro to Crosswalk

- Our job is to consider whether other elements should be "must pass" or other factors should be "critical" because they align with parts of our vision.
  - Are they essential to advancing health equity?
  - Are they essential to patient-centered care?
  - Are they essential to integrated Behavioral Health?
- To help up do this the crosswalk presents additional "must pass" elements or "critical factors" that we recommend for based on their alignment

# Patient-Centered Medical Home 2014

## (6 standards/27 elements)

1) **Patient-Centered Access (10)**
   - A) ***Patient-Centered Appointment Access (4.5)**
   - B) 24/7 Access to Clinical Advice (3.5)
   - C) Electronic Access (2)
2) **Team-Based Care (12)**
   - A) Continuity (3)
   - B) Medical Home Responsibilities (2.5)
   - C) Culturally and Linguistically Appropriate Services (2.5)
   - D) ***The Practice Team (4)**
3) **Population Health Management (20)**
   - A) Patient Information (3)
   - B) Clinical Data (4)
   - C) Comprehensive Health Assessment (4)
   - D) ***Use Data for Population Management (5)**
   - E) Implement Evidence-Based Decision Support (4)
4) **Care Management and Support (20)**
   - A) Identify Patients for Care Management (4)
   - B) ***Care Planning and Self-Care Support (4)**
   - C) Medication Management (4)
   - D) Use Electronic Prescribing (3)
   - E) Support Self-Care and Shared Decision Making (5)
5) **Care Coordination and Care Transitions (18)**
   - A) Test Tracking and Follow-Up (6)
   - B) ***Referral Tracking and Follow-Up (6)**
   - C) Coordinate Care Transitions (6)
6) **Performance Measurement and Quality Improvement (20)**
   - A) Measure Clinical Quality Performance (3)
   - B) Measure Resource Use and Care Coordination (3)
   - C) Measure Patient/Family Experience (4)
   - D) ***Implement Continuous Quality Improvement (4)**
   - E) Demonstrate Continuous Quality Improvement (3)
   - F) Report Performance (3)
   - G) Use Certified EHR Technology (0)

***Indicates Must Pass Element**

# Intro to Crosswalk (continued)

Impact of altering Must Pass/Critical:

•Critical Factor: must achieve factor to be eligible for points

"Must Pass" designation: must achieve score of 50% in the factors

**EXAMPLE - Standard 2: Team-based Care (12 Point Total)**

A: Continuity (3 points)

B: Medical Home Responsibility (2.5 points)

C: CLAS (2.5 Points)

D: The Practice Team **(Must-Pass)** (4 points)

- 10 factors total; to reach the 50% required pass threshold they must meet 5-7 factors including the "Critical Factor"

Adding critical factors will help to target the areas of focus.

# Intro to Crosswalk (continued)

- In making these recommendations we considered the recommendations of:
  - Planetree for patient centered care
  - Ignatius Bau, health equity and health policy consultant
- We made additional recommendations based on best practices
- Finally, we promised CMMI we would consider alignment with CMMI's Comprehensive Primary Care Initiative (CPCI) standards. We suggest additional CPCI aligned "must pass" elements or "critical factors" for consideration.

# Crosswalk

# Standard 1 - Patient-Centered Access

**No changes recommended**

- **Element A: Appointment Access (MUST-PASS)**
  - **1: Providing Same Day Appointments for routine and urgent care (CRITICAL FACTOR)**
- **Element B: 24/7 Clinical Advice Access**
  - **2: Providing timely clinical advice by telephone (CRITICAL FACTOR)**
- **Element C: Electronic Access**
  - **Important but already including in Meaningful Use requirement**

# Standard 2: Team-Based Care

- **Element A: Continuity**
- **Element B: Medical Home Responsibilities**
- **Element C: CLAS (MAKE MUST-PASS)**
  - **1: The practice uses data to assess the diversity and needs of its population so it can meet those needs adequately. Data may be collected by the practice from all patients directly or may be data about the community served by the practice. (MAKE CRITICAL FACTOR)**
  - **Note: Require collection from all patients directly**
  - **Areas of Emphasis - the practice should be knowledgeable about culturally appropriate services and health disparities among patient populations served by the practice.**

# Standard 2: Team-Based Care

- **Element D: The Practice Team (MUST PASS)**
  - **3: Holding scheduled patient care team meetings or structured communication process focused on individual patient care. (CRITICAL FACTOR)**
  - **Note: For Quality Improvement, the practice team needs ongoing mechanism for input, reactions, and areas for growth, especially in CLAS functions. Further discussion in Element 6C.**

# Standard 3: Population Health Management

- **Element A: Patient Information (EHR collection of…)**
  - **3: Race (Make CRITICAL FACTOR)**
  - **4: Ethnicity (Make CRITICAL FACTOR)**
  - **5: Preferred language (Make CRITICAL FACTOR)**
- **Element B: Clinical Data**

# Standard 3: Population Health Management

- **Element C: Comprehensive Health Assessment**
  - **2: Family/Social/Cultural characteristics (Make CRITICAL FACTOR)**
  - **10: Assessment of health literacy (Make CRITICAL FACTOR)**
  - **Note:**
    - Planetree: Recommends accommodations be made to integrate individual patients cultural norms, needs, and beliefs into their care and treatment plan upon request
    - HE: Understanding the health needs of the diverse patient populations being served can help inform what family/social/cultural characteristics might be most relevant in the care of an individual patient/family
  - **Add C11: Oral Health Screening/Assessment?**

# Standard 3: Population Health Management

**No changes**

- **Element D: Use Data for Pop Management (MUST-PASS)**
- **Element E: Evidence-Based Decision Support**
  - **1: A mental health or substance use disorder (CRITICAL FACTOR)**

# Standard 4: Care Management and Support

- **Element A: Identify Patients for Care Management**
  - **4: Social determinants of health (Make CRITICAL FACTOR)**
  - **6: The practice monitors the percentage of the total patient population identified through its process and criteria (CRITICAL FACTOR)**
- **Element B: Care Planning and Self-Care Support (MUST-PASS)**
  - **1: Incorporates patient preferences and functional/lifestyle goals (Make CRITICAL FACTOR)**
  - **6: New element: Have a process in place for when an adverse clinical event or unanticipated outcome occurs to provide support to patient/family and staff affected. This process includes full and empathetic disclosure to patient and family as appropriate. (Make CRITICAL FACTOR)**

# Standard 4: Care Management and Support

- **Element C: Medication Management**
  - **1: Reviews and reconciles medications for more than 50% of patients received from care transitions (CRITICAL FACTOR)**

**Note: care transitions include medical and behavioral health settings**

- **Element D: Use Electronic Prescribing**

# Standard 4: Care Management and Support

- **Element E: Support Self-Care and Shared Decision Making**
  - **2: Provides educational materials and resources to patients (Make CRITICAL FACTOR)**
  - **4: Adopts shared decision making tools (Make CRITICAL FACTOR)**
    - **CT SIM recommends for 2 health conditions – vendor task**
  - **6: Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates (Make CRITICAL FACTOR)**
  - Planetree: Provide meaningful discharge/care summaries in a manner that accommodates patient's level of understanding and a language they understand. Patients health & wellness needs are approached holistically & in consideration of person's expressed health goals and activities.

# Standard 4: Care Management and Support

**Proposed areas of emphasis:**

- Want 95% empanelment
- Risk-stratification for 75% of empanelled patients
- Provide 80% of high risk patients with care management
- Need to have implemented care plans and shared decision making tools for 2 health conditions

# Standard 5: Care Coordination and Care Transitions

- **Element A: Test Tracking and Follow-Up**
  - **1: Tracks lab tests until results are available, Flagging and following up on overdue results. (CRITICAL FACTOR)**
  - **2: Tracks imaging tests until results are available, Flagging and following up on overdue results. (CRITICAL FACTOR)**
  - **5: Notifies patients/family of normal and abnormal lab and imaging test results (Make CRITICAL FACTOR)**

# Standard 5: Care Coordination and Care Transitions

- **Element B: Referral Tracking and Follow-Up (Must Pass)**
  - **8: Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports (CRITICAL FACTOR)**
- **Element C: Coordinate Care Transitions**
  - **6: Obtains proper consent for release of information and has a process for secure exchange of information and for coordination of care with community partners (Make CRITICAL FACTOR)**

# Standard 5: Care Coordination and Care Transitions

**Proposed areas of emphasis** :

- SIM will also track % of patients with ED visits who received follow-up; contact 75% of patients who were hospitalized within 72 hours; collab agreements with at least 2 groups of high-volume specialties to improve care transitions.
- Metrics required for: asthma ED visits, Ambulatory Care Sensitive Condition hospitalizations, readmissions for avoidable complications, medication reconciliation.

# Standard 6: Performance Measurement and Quality Improvement

- **Element A: Measure Clinical Quality Performance**
  - **4: Performance data stratified for vulnerable populations (to assess disparities in care) (Make CRITICAL FACTOR)**
- **Element B: Measure Resource Use and Care Coordination**

# Standard 6: Performance Measurement and Quality Improvement

- **Element C: Measure Patient/Family Experience (Make MUST-PASS)**
  - **3: The practice obtains feedback on experiences of vulnerable patient groups (Make CRITICAL FACTOR)**
  - **4: The practice obtains feedback from patients/families through qualitative means (Make CRITICAL FACTOR)**

  Connects to 2D: The Practice Team

  - HE: Patients/families/caregivers from culturally and linguistically diverse backgrounds should be recruited for involvement in quality improvement activities or the practice's advisory council
  - Planetree: Patient experience need to be regularly assessed, patients/families need to be actively involved in the design, ongoing assessment, and communication of performance improvement.

# Standard 6: Performance Measurement and Quality Improvement

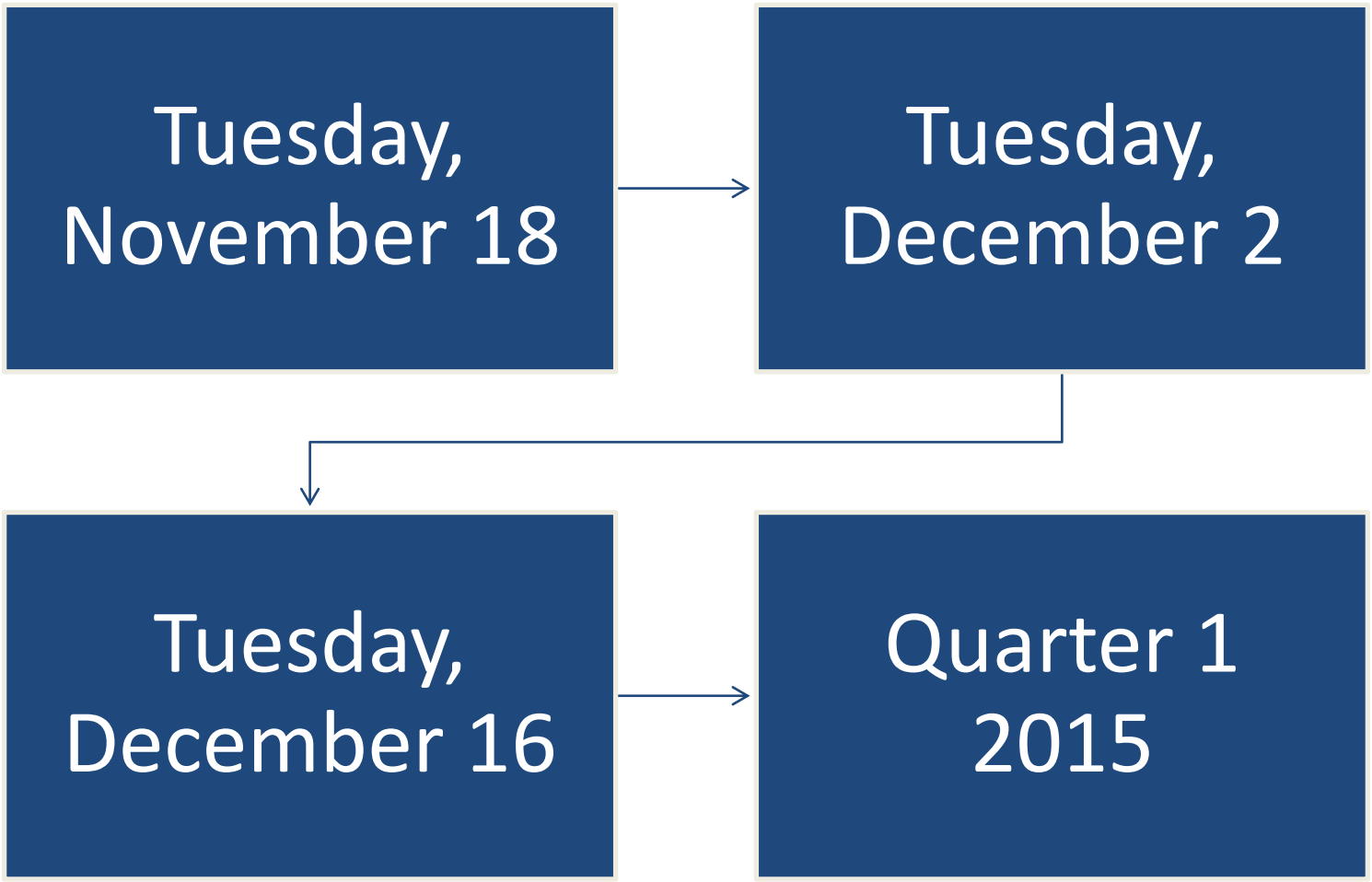
- **Element D: Implement Continuous Quality Improvement (MUST-PASS)**
  - **5: Set goals and analyze at least one patient experience measure (Make CRITICAL FACTOR)**
  - **7: Set goals and address at least one identified disparity in care/service for identified vulnerable population (Make CRITICAL FACTOR)**
- **Element E: Demonstrate Continuous Quality Improvement**
- **Element F: Report Performance**
- **Element G: Use of Certified EHR Technology**
  - **Eligibility requirement for participation in AMH Glide Path program**

# Standard 6: Performance Measurement and Quality Improvement

**Discussion Topics:**

- New Element or area of emphasis: primary care team satisfaction and engagement?
- New Element or area of emphasis: Create functioning and accountable Patient/Family Advisory Council
- Collaborate with the Quality Council

# Meeting Schedule



# Appendix

# NCQA Recognition

## PCMH 2014 SCORING

### Scoring Summary

| Recognition Levels | Required Points | Must-Pass Elements |
|---|---|---|
| Level 1 | 35–59 points | ▪ 6 of 6 elements are required for each level<br>▪ Score for each Must-Pass element must be ≥ 50% |
| Level 2 | 60–84 points | |
| Level 3 | 85–100 points | |

### 100 Points, 27 Elements, 6 Must-Pass Elements